CABINET FOR HEALTH AND FAMILY SERVICES
Department for Public Health
Division of Adult and Child Health Improvements

911 KAR 2:200. Coverage and payment for Kentucky Early Intervention Program services.

RELATES TO: 34 C.F.R. 303.520, 303.521, 303.527, 303.528, 20 U.S.C. 1371 to 1485
STATUTORY AUTHORITY: KRS 194A.030(7), 194A.050, 200.660(3), (7), 34 C.F.R. 303.520 - 303.528, 20 U.S.C. 1476(a)(12), 1478, EO 2004-726
NECESSITY, FUNCTION, AND CONFORMITY: EO 2004-726, effective July 9, 2004, reorganized the Cabinet for Health and Family Services and placed the Department for Public Health under the Cabinet for Health and Family Services. KRS 200.660 requires the cabinet to administer funds appropriated to implement the provisions of KRS 200.650 to 200.676, to enter into contracts with service providers, and to promulgate administrative regulations. This administrative regulation establishes the provisions relating to early intervention services for which payment shall be made on behalf of eligible recipients.

Section 1. Participation Requirements.

An early intervention provider that requests to participate as an approved First Steps provider shall comply with the following:

(1) Submit to an annual review by the Department for Public Health, or its agent, for compliance with 911 KAR Chapter 2;
(2) (a) Meet the qualifications for a professional or paraprofessional established in 911 KAR 2:150; or
(b) Employ or contract with a professional or paraprofessional who meets the qualifications established in 911 KAR 2:150;
(3) Ensure that a professional or paraprofessional employed by the provider who provides a service in the First Steps Program shall attend training on First Steps' philosophy, practices, and procedures provided by First Steps representatives prior to providing First Steps services;
(4) Agree to provide First Steps services according to an individualized family service plan as required in 911 KAR 2:130;
(5) Agree to maintain and to submit as requested by the Department for Public Health required information, records, and reports to insure compliance with 911 KAR Chapter 2;
(6) Establish a contractual arrangement with the Cabinet for Health and Family Services for the provision of First Steps services; and
(7) Agree to provide upon request information necessary for reimbursement for services by the Cabinet for Health and Family Services in accordance with this administrative regulation, which shall include the tax identification number and usual and customary charges.

Section 2. Reimbursement.

The Department for Public Health shall reimburse a participating First Steps provider the lower of the actual billed charge for the service or the fixed upper limit established in this section for the service being provided.

(1) A charge submitted to the Department for Public Health shall be the provider's usual and customary charge for the same service.
(2) The fixed upper limit for services shall be as follows:
(a) Primary service coordination. Primary service coordination shall be provided by face-to-face contact or by telephone on behalf of a child, with the parent of the child, a professional or other service provider, or other significant person in the family's life.
1. In the office, the fee shall be sixty-one (61) dollars per hour of service.
2. In the home or community site, the fee shall be eighty-three (83) dollars per hour of service.

(b) Initial service coordination. Initial service coordination shall be provided by face-to-face contact or by telephone on behalf of a child, with the parent of the child, a professional or other service provider, or other significant person.
1. In the office, the fee shall be sixty-eight (68) dollars per hour of service.
2. In the home or community site, the fee shall be ninety-one (91) dollars per hour of service.

(c) Primary level evaluation. The developmental component of the primary level evaluation for a non-established risk child shall be provided by face-to-face contact with the child and parent.
1. In the office or center based site, the fee shall be $225 per service event.
2. In the home or community site, the fee shall be $225 per service event.

(d) Five (5) Area Assessment. The developmental component of the primary level evaluation for the established risk child shall be provided by face-to-face contact with the child and parent.
1. In the office or center based site, the fee shall be $175 per service event.
2. In the home or community-based site, the fee shall be $175 per service event.

(e) Record Review. A record review shall be provided by a Department for Public Health approved team. The fee shall be $300 per service event.

(f) Intensive clinic evaluation. The intensive level evaluation shall be provided by face-to-face contact with the child and parent.
1. In the office or center-based site, which involves a board certified physician, the fee shall be $1,100 per service event.
2. In the community site, which involves a board certified physician, the fee shall be $1,100 per service event.
3. In the office or center-based site without a board certified physician, the fee shall be $400 per service event.
4. In the community site without a board certified physician, the fee shall be $400 per service event.

(g) Therapeutic intervention, service assessment or collateral services in accordance with Section 3(3), (4), (6) and (7) of this administrative regulation:
1. For an audiologist:
   a. In the office or center based site, the fee for a service assessment, collateral service or a therapeutic intervention including cotreatment shall be sixty-three (63) dollars per hour of service; or
   b. In the home or community site, the fee for a service assessment, collateral service or a therapeutic intervention including cotreatment shall be eighty-nine (89) dollars per hour of service.
2. For a family therapist:
   a. In the office or center based site, the fee for a service assessment, collateral service or a therapeutic intervention including cotreatment shall be sixty-three (63) per hour of service; or
   b. In the home or community site, the fee for a service assessment, collateral service or a therapeutic intervention including cotreatment shall be eighty-nine (89) per hour of service.
3. For a licensed psychologist or certified psychologist with autonomous functioning:
   a. In the office or center based site, the fee for a service assessment, collateral service or a therapeutic intervention including cotreatment shall be $139 per hour of service; or
   b. In the home or community site, the fee for a service assessment, collateral service or a therapeutic intervention including cotreatment shall be $203 per hour of service.
4. For a certified psychological associate:
   a. In the office or center based site, the fee for a collateral service or a therapeutic intervention including cotreatment shall be $104 per hour of service; or

b. In the home or community site, the fee for a collateral service or a therapeutic intervention including cotreatment shall be $153 per hour of service.

5. For a developmental interventionist:
   a. In the office or center based site, the fee for a service assessment, collateral service or a therapeutic intervention including cotreatment shall be sixty-one (61) dollars per hour of service; or
   b. In the home or community site, the fee for a service assessment, collateral service or a therapeutic intervention including cotreatment shall be eighty-one (81) dollars per hour of service.
6. For a developmental associate:
   a. In the office or center based site, the fee for a collateral service or a therapeutic intervention including cotreatment shall be forty-five (45) dollars per hour of service; or
   b. In the home or community site, the fee for a collateral service or a therapeutic intervention including cotreatment shall be sixty-eight (68) dollars per hour of service
7. For a registered nurse:
   a. In the office or center based site, the fee for a service assessment, collateral service or a therapeutic intervention including cotreatment shall be sixty-three (63) dollars per hour of service; or
   b. In the home or community site, the fee for a service assessment, collateral service or a therapeutic intervention including cotreatment shall be eighty-nine (89) dollars per hour of service
8. For a licensed practical nurse:
   a. In the office or center based site, the fee for a collateral service or a therapeutic intervention including cotreatment shall be twenty-four (24) dollars per hour of service; or
   b. In the home or community site, the fee for a collateral service or a therapeutic intervention including cotreatment shall be thirty-two (32) dollars per hour of service
9. For a nutritionist:
   a. In the office or center based site, the fee for a service assessment, collateral service or a therapeutic intervention including cotreatment shall be sixty-three (63) dollars per hour of service; or
   b. In the home or community site, the fee for a service assessment, collateral service or a therapeutic intervention including cotreatment shall be eighty-nine (89) dollars per hour of service.
10. For a dietitian:
    a. In the office or center based site, the fee for a service assessment, collateral service or a therapeutic intervention including cotreatment shall be sixty-three (63) dollars per hour of service; or
    b. In the home or community site, the fee for a service assessment, collateral service or a therapeutic intervention including cotreatment shall be eighty-nine (89) dollars per hour of service.
11. For an occupational therapist:
    a. In the office or center based site, the fee for a service assessment, collateral service or a therapeutic intervention including cotreatment shall be sixty-three (63) dollars per hour of service; or
    b. In the home or community site, the fee for a service assessment, collateral service or a therapeutic intervention including cotreatment shall be eighty-nine (89) dollars per hour of service.
12. For an occupational therapist assistant:
    a. In the office or center based site, the fee for a collateral service or a therapeutic

intervention including cotreatment shall be forty-six (46) dollars per hour of service; or
b. In the home or community site, the fee for a collateral service or a therapeutic intervention including cotreatment shall be seventy (70) dollars per hour of service.

13. For an orientation and mobility specialist:
    a. In the office or center based site, the fee for a service assessment, collateral service or a therapeutic intervention including cotreatment shall be sixty-one (61) dollars per hour of service; or
    b. In the home or community site, the fee for a service assessment, collateral service or a therapeutic intervention including cotreatment shall be eighty-one (81) dollars per hour of service.
14. For a physical therapist:
    a. In the office or center based site, the fee for a service assessment, collateral service or a therapeutic intervention including cotreatment shall be sixty-three (63) dollars per hour of service; or
    b. In the home or community site, the fee for a service assessment, collateral service or a therapeutic intervention including cotreatment shall be eighty-nine (89) dollars per hour of service.
15. For a physical therapist assistant:
    a. In the office or center based site, the fee for a collateral service or a therapeutic intervention including cotreatment shall be forty-six (46) dollars per hour of service; or
    b. In the home or community site, the fee for a collateral service or a therapeutic intervention including cotreatment shall be seventy (70) dollars per hour of service.
16. For a speech therapist:
    a. In the office or center based site, the fee for a service assessment, collateral service or a therapeutic intervention including cotreatment shall be sixty-three (63) dollars per hour of service; or
    b. In the home or community site, the fee for a service assessment, collateral service or a therapeutic intervention including cotreatment shall be eighty-nine (89) dollars per hour of service.
17. For a social worker:
    a. In the office or center based site, the fee for a service assessment, collateral service or a therapeutic intervention including cotreatment shall be sixty-one (61) dollars per hour of service; or
    b. In the home or community site, the fee for a service assessment, collateral service or a therapeutic intervention including cotreatment shall be eighty-one (81) dollars per hour of service.
18. For a teacher of the deaf and hard of hearing:
    a. In the office or center based site, the fee for a service assessment, collateral service or a therapeutic intervention including cotreatment shall be sixty-one (61) dollars per hour of service; or
    b. In the home or community site, the fee for a service assessment, collateral service or a therapeutic intervention including cotreatment shall be eighty-one (81) dollars per hour of service.
19. For a teacher of the visually impaired:
    a. In the office or center based site, the fee for a service assessment, collateral service or a therapeutic intervention including cotreatment shall be sixty-one (61) dollars per hour of service; or
    b. In the home or community site, the fee for a service assessment, collateral service or a therapeutic intervention including cotreatment shall be eighty-one (81) dollars per hour of service.

20. For a physician providing a collateral service in the office or center based site, the fee shall be seventy-six (76) dollars per hour of service. A physician shall not receive reimbursement for therapeutic intervention.
21. For an assistive technology specialist:
    a. In the office or center based site, the fee for a service assessment, collateral service or a therapeutic intervention including cotreatment shall be sixty-one (61) dollars per hour of service; or
    b. In the home or community site, the fee for a service assessment, collateral service or a therapeutic intervention including cotreatment shall be eighty-one (81) dollars per hour of service.

(h) Respite shall be seven (7) dollars and sixty (60) cents per hour.

(3)(a) For therapeutic intervention, service assessment or collateral services, units shall be determined using the beginning and ending time for a service documented in staff notes.

1. The staff notes shall include:
    a. The child's name and CBIS number;
    b. Time in and time out;
    c. Location;
    d. Method of delivery;
    e. A description of what happened during the session, the child's response and future action to be taken;
    f. Staff title and signature; and
    g. Date.
2. The units shall be computed as follows:
    a. Fifteen (15) to twenty-nine (29) minutes equal one (1) unit;
    b. Thirty (30) to forty-four (44) minutes equal two (2) units;
    c. Forty-five (45) to fifty-nine (59) minutes equal three (3) units; and
    d. Sixty (60) to seventy-four (74) minutes equal four (4) units.

(b) For service coordination services, units shall be determined using the beginning and ending time for a service documented in staff notes in accordance with paragraph (a) of this subsection.

1. The units shall be computed as follows:
    a. One (1) to twenty-two (22) minutes equal one (1) unit;
    b. Twenty-three (23) to thirty-seven (37) minutes equal two (2) units;
    c. Thirty-eight (38) to fifty-two (52) minutes equal three (3) units; and
    d. Fifty-three (53) to sixty-seven (67) minutes equal four (4) units.
2. Service coordination minutes spent over the course of a day on a child or family shall be accumulated at the end of the day in order to determine the number of units used.

(4) A payment for a primary or intensive evaluation listed in subsection (2) of this section shall be based on a complete evaluation as a single unit of service.

(5) Payment for assistive technology devices shall be made in accordance with those approved by the Department for Public Health.

(6) Payment for transportation shall be the lesser of the billed charge or:
(a) For a commercial transportation carrier, an amount derived by multiplying one (1) dollar by the actual number of loaded miles using the most direct route;
(b) For a private automobile carrier, an amount equal to twenty-five (25) cents per loaded mile transported; or
(c) For a noncommercial group carrier, an amount equal to fifty (50) cents per eligible child per mile transported.

(7) A payment for a group intervention service shall be thirty-two (32) dollars per child per hour of direct contact service for each child in the group with a limit of three (3) eligible children per

professional and paraprofessional who can practice without direct supervision.

Section 3. Limitations.

(1) For primary service coordination, payment shall be limited to no more than ten (10) hours (or forty (40) units) per child per six (6) month period unless preauthorized by the Department for Public Health. A prior authorization request to exceed service coordination limits shall be sent to the Department for Public Health in accordance with Section 4 of this administrative regulation.

(2) For initial service coordination, payment shall be limited to no more than twenty-five (25) hours (or 100 units) per child per period of eligibility unless preauthorized by the Department for Public Health in accordance with Section 4 of this administrative regulation.

(3) For service assessment:

(a) Payment shall be limited to no more than two and one-half (2 1/2) hours per child per discipline per assessment unless preauthorized by the Department for Public Health in accordance with Section 4 of this administrative regulation.

(b) Payment shall be limited to three (3) assessments per discipline per child from birth to the age of three (3) unless preauthorized by the Department for Public Health in accordance with Section 4 of this administrative regulation.

(c) A service assessment payment shall not be made for the provision of routine therapeutic intervention services by a discipline in the general practice of that discipline. Payment for a unit of service assessment shall be restricted to the needs for additional testing or other activity by the discipline that go beyond routine practice. Routine activity of assessing outcomes shall be billed as therapeutic intervention.

(d) Payment shall be limited to an assessment provided as a face-to-face contact with the child and parent.

(4) For therapeutic intervention, unless prior authorized by the Department for Public Health in accordance with Section 4 of this administrative regulation, limitations for payment of services shall be as follows:

(a) For office, center or home and community sites:

1. Payment shall be limited to no more than one (1) hour per day per child per discipline by a:
   a. Professional meeting the qualifications established in 911 KAR 2:150; or
   b. Paraprofessional meeting the qualifications established in 911 KAR 2:150.
2. Payment shall be limited to no more than ninety-six (96) units for a single discipline and 144 units for more than one discipline during a six (6) month period and for group shall be limited to an additional 192 units during a six (6) month period.

(b) For group:

1. Children shall not be eligible for both group and individual therapy in the same developmental domain concurrently on the IFSP.
2. Group providers shall be pre-approved by the Department for Public Health.
3. The ratio of staff to children in group therapeutic intervention shall be limited to a maximum of three (3) children per professional and paraprofessional per group.

(c) Payment for siblings seen at the same time shall be calculated by dividing the total time spent by the number of siblings to get the amount of time to bill per child.

(d) Payment for a service shall be limited to a service that is authorized by the entire IFSP team in accordance with 911 KAR 2:130, Section 2(6) or (7).

(e) Payment shall be limited to a service provided as a face-to-face contact with the child and either the child's parent or caregiver.

(5) For respite, payment shall:

(a) Be limited to no more than eight (8) hours of respite per month, per eligible child;

(b) Not be allowed to accumulate beyond each month; and
(c) Be limited to families in crisis, or strong potential for crisis without the provision of respite.

(6) For collateral services, payment for:
(a) Length of an IFSP meeting shall be limited to four (4) billable units:
(b) Attendance at one (1) ARC meeting held prior to a child's third birthday shall be limited to the service coordinator and two (2) professionals or paraprofessionals selected by the IFSP team;
(c) Participation at an initial IFSP meeting by a primary level evaluator shall be limited to an evaluator who has provided feedback and interpretation of the evaluation to the family prior to the IFSP meeting in accordance with 911 KAR 2:120, Section 1(4)(e)2b. Payment shall be at the collateral services rate for the discipline that the evaluator represents; and
(d) A face-to-face attendance at an IFSP meeting or a face-to-face or telephone consultation by a team member with a child's physician for developmentally-related needs shall be provided.

(7) For cotreatment, payment shall be limited to three (3) disciplines providing services concurrently.

(8) Unless prior authorized by the Department for Public Health due to a shortage of primary level evaluators, a primary level evaluator shall not be eligible to provide therapeutic intervention to a child whom he evaluated and which resulted in the child becoming eligible.

Section 4. Prior Authorization Process.

(1) Requests for payment for therapeutic intervention services beyond the limits established in Section 3 of this administrative regulation shall be submitted to the Payment Authorization Coordinator, as determined by the Department for Public Health, 275 East Main Street, Frankfort, KY 40621 prior to the service being delivered and shall include the following:
(a) A service exception request describing:
1. Current IFSP team members;
2. Current services;
3. Description of current developmental status;
4. Family input;
5. Additional services requested; and
6. Rationale for the additional services;
(b) The medical component of the primary level evaluation in accordance with 911 KAR 2:120, Section 1(4)(e)1, which shall include the following:
1. History;
2. Physical exam;
3. Hearing screening;
4. Vision screening; and
5. Other available reports from medical specialists;
(c) Developmental evaluation reports in accordance with 911 KAR 2:120, Section 1(4)(e)2, which shall include the following:
1. Primary level evaluation report; and
2. Intensive level evaluation report, if applicable;
(d) IFSP team member reports completed within the last twelve (12) months by the disciplines involved, including:
1. Assessments; and
2. Six (6) month progress reports;
(e) IFSP documents from the last twelve (12) months, including amendments;
(f) Payor of Last Resort Form, along with available supporting documentation, including:
1. Requests submitted to other payors; and
2. Responses from payor sources;

(g) Transfer of Skills Form; and
(h) Service Planning Activity Matrix Form.

(2) Requests for payment for service coordination services beyond the limits established in Section 3 of this administrative regulation shall be submitted to the Payment Authorization Coordinator, as determined by the Department for Public Health, prior to the service being delivered and shall include:
(a) A service exception request as required by subsection (1)(a) of this section;
(b) A copy of the current IFSP; and
(c) A detailed description of how and when the additional units are to be used.

(3) If the IFSP team is not in agreement with the decision of the Record Review team:
(a) A request for further review shall be submitted to the Department for Public Health; and
(b) A three (3) person team from the Department for Public Health, Division of Adult and Child Health Improvement, including the division director, shall render a recommendation.

(4) If the IFSP team is not in agreement with the three (3) person team recommendation established in subsection (3)(b) of this section:
(a) The child's IFSP team shall be asked to reconvene for a IFSP meeting with a representative from the record review team and a representative from the three (3) member team; and
(b) If the IFSP team concludes at that IFSP meeting that the services are still needed, payment for the service shall be authorized for the duration of the current IFSP.

Section 5. Sliding Fee.

(1) Families shall pay for services based on a sliding fee scale, except that a charge shall not be made for the following functions:
(a) Child find;
(b) Evaluation and assessment;
(c) Service coordination; and
(d) Administrative and coordinative activities including development, review, and evaluation of individualized family service plans, and the implementation of procedural safeguards.

(2) Payment of fees shall be for the purpose of:
(a) Maximizing available sources of funding for early intervention services; and
(b) Giving families an opportunity to assist with the cost of services where there is means to do so, in a family share approach.

(3) The family share payment shall:
(a) Be explained to the family by the service coordinator;
(b) Be an income-based monthly fee, and with the exception established in paragraph (d) of this subsection, shall begin in the month of the IFSP, at the time therapeutic services are authorized, and continuing for the duration of participation in early intervention services, as determined by the:
1. Level of family gross income identified on the last Federal Internal Revenue Service statement or check stubs from the four (4) most recent consecutive pay periods, as reported by the family; and
2. Level of income matched with the level of poverty, utilizing the federal poverty measure, poverty guidelines as published annually by the Federal Department of Health and Human Services, based on the following scale:
a. Below 200 percent of poverty, there shall be no payment;
b. From 200 percent of poverty to 299 percent, the payment shall be twenty (20) dollars per month of participation;
c. From 300 percent of poverty to 399 percent, the payment shall be thirty (30) dollars per month of participation;
d. From 400 percent of poverty to 499 percent, the payment shall be forty (40) dollars per

month of participation;

e. From 500 percent of poverty to 599 percent, the payment shall be fifty (50) dollars per month of participation; or

f. From 600 percent of poverty and over, the payment shall be $100 per month of participation;

(c) Not apply to a child receiving Medicaid or Kentucky Children's Health Insurance Program (KCHIP) benefits;

(d) Not apply to a family who receives only evaluation, assessment, service coordination services or IFSP development in the initial calendar month of eligibility. The initial service coordinator shall notify the Department for Public Health First Steps financial case manager immediately if the initial IFSP date is different than the month that therapeutic intervention services are started;

(e) Not apply to a family that does not receive services except those described in paragraph (d) of this subsection for at least one (1) month if prior authorized by the Department for Public Health First Steps financial case manager in accordance with paragraph (g)1 and 2 of this subsection. A request shall not be submitted for a retroactive period unless an extenuating circumstance occurs such as an unexpected hospitalization;

(f) Not apply to a family that receives evaluation, assessment, service coordination, or IFSP development if the developmental evaluation or assessment did not reveal a developmental delay. The service coordinator shall notify the Department for Public Health financial case manager immediately if this situation exists so that the family is not assessed a family share cost;

(g) Not prevent a child from receiving services if the family shows to the satisfaction of the Department for Public Health an inability to pay, in accordance with the following:

1. The service coordinator shall submit to the Department for Public Health First Steps financial case manager, on behalf of the family, a waiver request to have the amount of the family share payment reduced or eliminated for a period not to exceed three (3) calendar months. A request shall not be submitted for a retroactive period unless extenuating circumstances, such as an unexpected hospitalization, occurs.

2. The family shall undergo a financial review by the Department for Public Health that may:

a.(i) Adjust the gross household income by subtracting extraordinary medical costs, equipment costs, exceptional child care costs, and other costs of care associated with the child's other family members' disabilities; and

(ii) Result in a calculation of a new family-share payment amount based on the family's adjusted income compared to the percentage of the poverty level established in paragraph (b)2 of this subsection. If a recalculation is completed, the Department for Public Health shall conduct a review at least quarterly; or

b. Suspend or reduce the family-share payment, based on a verified financial crisis that would be exacerbated by their obligated family share payment. The Department for Public Health shall conduct a review at least quarterly; and

(h) Except for a family that refuses to apply for Medicaid in accordance with subsection (6) of this section, not apply to a family who chooses to use their private insurance if the amount of the insurance monies received and applied to the family's services in the calendar year is equal to or greater than the sum of the obligated amount of family share during the same calendar year. Refunding of family share collected up to the amount of the private insurance reimbursement shall occur after the end of a calendar year.

(4) Income and insurance coverage shall be verified at six (6) month intervals, and more often if changes in household income shall result in a change in the amount of the obligated family share payment. If a change in the family share category occurs, it shall become effective the month following the month the change was reported.

(5) A family that refuses to have its income verified shall be assessed a family share payment of $100 per month of participation.
(6) Unless there is a religious reason for not applying for Medicaid or KCHIP, a family that is potentially eligible for and refuses to apply for Medicaid or KCHIP shall be assessed a family share payment of $100 per month of participation. A review of a child's potential Medicaid eligibility shall occur every six (6) months. If the child is potentially eligible for Medicaid, within sixty (60) days of being advised to apply, the family shall provide the service coordinator with notification of the disposition of the inquiry into Medicaid eligibility.
(7) If multiple children in a family receive early intervention services, the family share payment shall be the same as if there were one (1) child receiving services.
(8) If a family has the ability to pay the family share but refuses to do so for three (3) consecutive months, the family shall receive service coordination and assessment services only until discharged from the program or the family share balance is paid in full, whichever occurs first.
(9) A family who chooses to use private insurance for payment of a First Steps service shall not be responsible for payment of insurance deductibles or copayments related to this service. First Steps shall assume payment of First Steps-related coinsurance and deductibles.
(10) With the exception of a discipline identified in 911 KAR 2:130, Section 2(9)(g)3j,k, or l, a provider shall bill a third-party insurance, if any, for a therapeutic intervention service prior to billing First Steps. Documentation regarding the billing, the third-party insurance representative's response, and payment, if any, shall be maintained in the child's record and submitted with the First Steps bill.

Section 6. Incorporation by Reference.
(1) The following material is incorporated by reference:
(a) Payor of Last Resort Form, October 2004;
(b) Transfer of Skills Form, October 2004.
(c) Service Planning Activity Matrix Form, October 2004; and
(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Public Health, 275 East Main Street, Frankfort, KY 40621, Monday through Friday, 8 a.m. to 4:30 p.m. (24 Ky.R. 811; Am. 1109; eff. 11-14-97; 25 Ky.R. 672; 1420; 1663; eff. 1-19-99; Recodified from 908 KAR 2:200, 10-25-2001; 29 Ky.R. 2795; 30 Ky.R. 330; 630; 893; eff. 8-20-03; 31 Ky.R. 502; 1427; eff. 2-22-05.)